Trainer Resource Guide

5. Medication Management: Part 2

Cautionary Statement

The material in this session is not intended to be medical advice on personal health matters. Medical advice should be obtained from a licensed physician. This session highlights medication. This session does not cover all situations, precautions, interactions, adverse reactions, or other side effects. A pharmacist can assist you and the doctor with questions about medications. We urge you to talk with pharmacists, nurses and other professionals (e.g. dietitians) as well, to broaden your understanding of the fundamentals covered in this module.

Trainer Guide: SESSION 5

Materials

- LCD projector and computer with PowerPoint software
- DSP TV video, Year 1
- Chart paper
- Colored markers
- Masking tape
- Ask students to share what they learned about possible side effects.

Show Slide #1: Medication Management, Part 2

Show Slide #2: Practice and Share, Session 4 and review assignment

- In this session you will have an opportunity to practice the medication skill check. You will also learn more about medication safety.
- The session will begin with a video and review of the Five Rights for assisting with the self-administration of medication.

Show Slide #3: DSP TV, Scene 11: The Five "Wrongs"

- Discuss and answer questions at the end of Scene 11. Use this as an opportunity to review the Five Rights (Session 4, S-11 and S-12).

  Answers

  — What mistakes did you observe? *The medication was not in a locked cabinet, the DSP did not check the label once, let alone three times, and the DSP guessed the dosage. She also did not wash her hands and gave Dominic a dirty glass from which to drink.*

  — What were the risks to Dominic? *Dominic could have become seriously ill or even died as a result of the DSP's negligence.*

  — How would you do it differently? *Follow the Five Rights.*

OUTCOMES

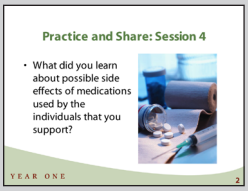
Show Slides #4 and #5: Outcomes

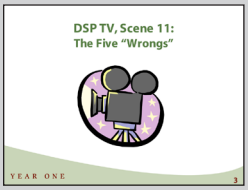
- Review outcomes for the session.

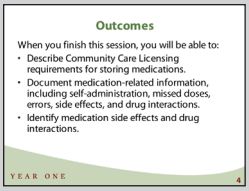
KEY WORDS

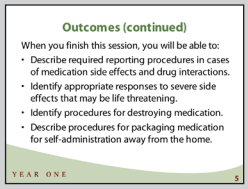
Show Slides #6 and #7: Key Words

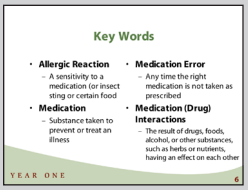
- Review key words for the session.
- Give students 5 minutes to think about and rewrite definitions in their own words in the spaces provided.

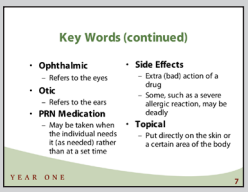












Student Resource Guide: SESSION 5

Medication Management: Part 2

OUTCOMES

When you finish this session, you will be able to:

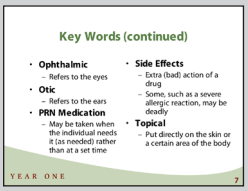
- Describe Community Care Licensing requirements for storing medications.
- Document medication-related information, including: self-administration, missed doses, errors, side effects, and drug interactions.
- Identify medication side effects and drug interactions.
- Describe required reporting procedures in cases of medication side effects and drug interactions.
- Identify appropriate responses to severe side effects that may be life threatening.
- Identify procedures for destroying medication.
- Describe procedures for packaging medication for self-administration away from the home.

KEY WORDS

Key Word	Meaning	In My Own Words
Allergic Reaction	A physical reaction caused by an unusual sensitivity to a medication (or insect sting or certain food).	
Medication	Substance taken to prevent or treat an illness.	
Medication Error	Any time the right medication is not taken as prescribed.	
Medication (Drug) Interactions	The result of drugs, foods, alcohol, or other substances, such as herbs or nutrients, having an effect on each other.	
Ophthalmic	Refers to the eyes.	
Otic	Refers to the ears.	
PRN (*pro re nata*) Medication	PRN is an abbreviation that means "as needed." PRN medication may be taken when the individual needs it rather than at a set time.	
Side Effects	An extra and usually bad action or effect that a drug has in addition to treating an illness. Some side effects, such as a severe allergic reaction, can be deadly.	
Topical	Put directly on the skin or a certain area of the body.	

ACTIVITY: What Do You Want to Know?

- Read directions aloud.
- Ask for student volunteers to share answers.
- Make note of student answers and link back to student knowledge
- and interests as appropriate as you review session content.
- At the end of this session you will return to this activity to give students an opportunity to answer the third question.



ACTIVITY

What Do You Want to Know?

Directions: Think about the topic of this training session. Answer the first two questions in the space provided below. You will come back to this page at the end of the session to answer the last question.

What do you **already know** about handling and storing medications?

What do you **want to know** about handling and storing medications?

To be answered at the end of the session, during review:
What **have you learned** about handling and storing medications?

Show Slide #8: Ordering and Storing Medications in Licensed Care Facilities and review the following information.

Ordering Medication

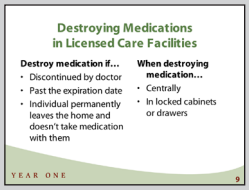
- It is a good idea to order refills a week before running out.
- New medications should be ordered immediately after being prescribed by the doctor.

Storage

- All medication in a licensed community care facility home must be centrally stored in locked cabinets or drawers, unless ordered otherwise.
- Community Care Licensing regulations require that all centrally stored medications entering the home be logged in a Centrally Stored Medication and Destruction Log.
- This information relates to a session outcome and may be covered on the quiz.

  Outcome: Describe Community Care Licensing requirements for storing medication.

Show Slide #9: Destroying Medications in Licensed Care Facilities



- If a medication is discontinued by the doctor, or is past the expiration date on the label, or if a person permanently leaves the home and does not take the medication to his/her new residence, the medication must be returned to the pharmacy or destroyed by the facility administrator or designee.
- Destruction of medications should be documented on the Medication Log and the Medication Destruction Log. Refer students to Appendix 5-A on S-17 for an example of a centrally stored Medication and Destruction Log.
- Each facility should have a procedure for the destruction of medication. Tell students to familiarize themselves with that procedure.
- This information relates to a session outcome and may be covered on the quiz.

  Outcome: Identify procedures for destroying medications.

Handling Medications in Licensed Care Facilities

In this session you will learn about correct handling, ordering and storing of medications; recording and reporting medication errors; recording and problem-solving when an individual refuses a dose of medication; and assisting with self-administration of PRN medications. You will also learn more about observing, reporting, and recording medication side effects and drug interactions.

Ordering Medications from the Pharmacist

It is essential that medications are ordered from the pharmacist on a regular basis so that the individual always has needed medication. It is a good idea to order refills a week before running out. New medications should be ordered immediately after being prescribed by the doctor.

Storage

Community Care Licensing regulations require that all medications entering the home be logged in a Centrally Stored Medication and Destruction Record (Appendix 5-A). A record of centrally stored medications for each individual must be maintained for at least one year.

All medication in a licensed community care facility home must be centrally stored in locked cabinets or drawers, unless ordered otherwise. The medications must be stored as directed by the medication label instructions (refrigerated, or at room temperature, or out of direct sunlight, etc.).

If a centrally stored medication requires refrigeration, it must be in a locked container, separate from food items. It is recommended that you use a thermometer and keep the refrigerator in the 36–40 degree range.

If an individual takes medication without assistance, the medication must be locked in a secure place, such as a bedside drawer, in the individual's room.

Destruction

Medications must be returned to the pharmacy or destroyed, if:

- a medication is permanently discontinued by the doctor, or
- is past the expiration date on the label, or
- an individual permanently leaves the home and does not take his or her medicine to their new residence.

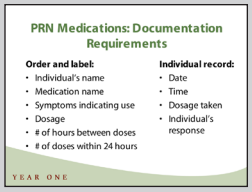
The medication must be returned to the pharmacy or destroyed by the facility administrator or designee in the presence of another adult who is not a resident. Multidose packages must be returned to the pharmacy when a medication is discontinued. Document return or destruction of medications on the Medication Log and on the Medication Destruction Log required by Community Care Licensing.

Each facility should have a written procedure for the destruction of medication. You may also ask the pharmacist for information about the proper method of destruction of a specific medication.

Show Slide #10: PRN Medications: General Requirements and review.

Ask the students what is required before "as needed" medication can be used? Before an "as needed" medication can be used, one needs a physician's order which indicates dose, how long before a second (or third, fourth) dose is given, maximum dose over twenty-four hour period, what the medication is for, when to stop, and when to contact physician for reevaluation and it must be in the individual's record. A record must be kept of each dose of "as needed" medications taken.

Show Slide #11: PRN Medications: Documentation Requirements and review.



PRN Medications

PRN medication is taken "as needed" to treat a specific symptom. PRN medications include both prescription and over-the-counter medications. PRN medications must always be ordered by a doctor. Community Care Licensing has established specific requirements for staff to assist individuals with self-administration of PRN medications.

Community Care Licensing Requirements for PRN Medications for Children and Adults

In CCFs, how PRN medications are handled depends upon the individual's needs and the type of facility. For every prescription and over-the-counter (nonprescription) PRN medication for which the DSP provides assistance there must be a signed, dated written order from a doctor, on a prescription blank or on the doctor's business stationery, maintained in the individual's file, and a label on the medication. Both the doctor's order and the label shall contain all of the following information:

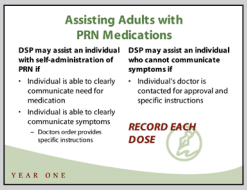
- Individual's name
- Name of the medication
- The specific symptoms that indicate the need for the use of the medication.
- The exact dosage.
- The minimum number of hours between doses.
- The maximum number of doses allowed in each 24-hour period.

Each dose of PRN medication should be recorded on the individual's Medication Log.

- This information relates to an outcome and may appear on the quiz.

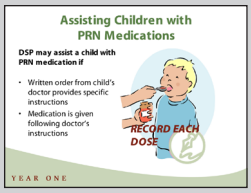
  Outcome: Document medication-related information including: self-administration, missed doses, errors, side effects, and drug interactions.

Show Slide #12: Assisting Adults with PRN Medications



- *If, in the written judgment of the physician, an individual has the ability to relate symptoms ("I have a headache") and communicate that he or she wants to take medication ("I want two aspirin"), DSPs in a Community Care Facility may assist a person with the medication.*
- *If the individual cannot determine need and cannot communicate symptoms clearly, DSPs (except in small family homes for children) need to contact the physician for instructions before each dose.*

Show Slide #13: Assisting Children with PRN Medications



- Review the instructions that DSPs must follow to assist children with PRN medications using the bulleted information in the Student Guide.
- See Session 4, page S-34 for specific licensing requirements.

Additional Requirements for Assisting Adults with PRN Medication

In an adult residential facility:

1. The DSP may assist an individual with self administration of his or her prescription or over-the-counter PRN medication when the doctor has stated in writing the individual is able to determine and clearly communicate his or her need for the PRN medication. The doctor's signed, dated statement must be kept in the individual's record.
2. The DSP may assist an individual with self administration of his or her over-the-counter PRN medication when the doctor had stated in writing that the individual is unable to determine his or her need for the over-the-counter medication, but is able to clearly communicate the symptoms. The doctor's signed, dated statement must be kept in the individual's record.
    - The doctor's written order must also provide instructions regarding when the medication should be stopped, and instructions for when the doctor should be contacted for reevaluation.
    - A record of each dose, including the date, time, and dosage taken, and the individual's response, must be kept in the individual's record.
3. DSPs designated by the administrator may assist an individual with self administration of his or her prescription or over-the-counter PRN medication when the individual is unable to clearly communicate his or her symptoms.
    - Before assisting with each dose, the DSP must contact the individual's doctor, describe the symptoms and receive persmission for assisting the individual.
    - The DSP must write the date and time of each contact with the doctor, the doctor's directions, and maintain this information in the individual's record.
    - A record of each dose, including the date, time and dosage taken, and the individual's response, must be kept in the individual's record.

Additional Requirements for Assisting Children With PRN Medications

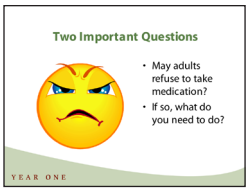
In a small family home for children, the DSP may assist a child with a prescription or over-the-counter PRN medication without contacting the doctor before each dose when the child is unable to determine and/or communicate his or her need for the PRN medication when:

- In addition to the information on the doctor's order and the medication label required for all CCFs, the doctor's written order for children in a small family home must also provide instructions regarding when the medication should be stopped, and instructions for when the doctor should be contacted for reevaluation.
- The medication must be given following the directions in the written doctor's order.
- A record of each dose, including the date, time and dosage taken, and the individual's response, must be kept in the individual's record.

Remember: *For both children and adults, for every PRN medication for which the DSP provides assistance there must be a signed, dated written order from a doctor, on a prescription form, maintained in the individual's record, and a label on the medication.*

- This information relates to an outcome and may appear on the quiz.

  Outcome: Document medication-related information including: self-administration, missed doses, errors, side effects, and drug interactions.



Show Slide #14: Two Important Questions and discuss.

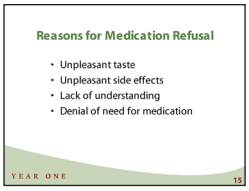
Answers

— May adults refuse to take medication? *Yes. Adults have a right to refuse medication.*

— If so, what do you need to do? *Most of the time the DSP can figure out a way to encourage the individual to take his or her prescribed medication, without being coercive. It is <u>not</u> okay to disguise medication in food or liquid – that is, to sneak it into the individual's body. Besides charting the refusal, it's important to alert the doctor right away. The doctor may be able to figure out a way to accommodate an individual's medication preference or special health consideration. The dose should be set aside and destroyed in an acceptable way.*

Refusal of Medications

- Adults have the right to refuse medication.
- The role of the DSP is to support the individual in taking the medication by listening to what the individual's concern are and trying to address them.
- Medication refusal needs to be documented on the medication record and brought to the attention of the prescribing doctor.



Show Slide #15: Reasons for Medication Refusal and discuss reasons why individuals may be refusing medication.

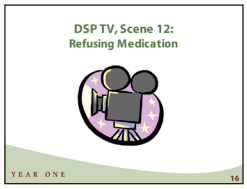
- Ask students what kinds of things they could do to help individuals with their concerns.

  — Unpleasant taste: *If allowed with a particular medication, provide crackers, apple, or juices afterwards to help cover the bad taste. Encourage individual to brush teeth or use mouthwash after taking medication.*

  — Unpleasant Side Effect (drowsiness): *Report unpleasant side effect to doctor ask if the medication can be taken before bedtime.*

  — Lack of Understanding: *Provide simple reminders on what the name of the medication is and what it does.*

  — Denial of Need for Medication: *Discuss, do not argue.*



Show Slide #16: DSP TV, Scene 12: Refusing Medication. Click on the icon to show the video.

- Discuss and answer questions at the end of Scene 12.

Answers

— What mistakes did you observe? *The DSP ignored David's right to refuse medication and tried to trick him into taking it. She also did not attempt to find out why David was refusing the medication and to try to resolve those issues. The DSP did not document the refusal or call the doctor.*

— Why might David be refusing his medication? *Perhaps the medication doesn't taste good to him or has unpleasant side effect. Or maybe David doesn't understand what the medication does, or doesn't think he needs the medication.*

— How would you do it differently? *Ask David why he is refusing the medication. If he still does not want to take the medication, call the prescribing doctor to notify them and to see if they can accommodate a special need or preference. Document your contact with the doctor and David's refusal on the medication record.*

Refusal of Medications

An individual has the right to refuse his or her medication. It is the DSP's responsibility to work with and support the individual in taking his or her medicine. If an individual refuses to take the medication, ask "Why?" Do not try to crush or hide the medication in the individual's food to get him or her to take the medicine.

Reasons for Medication Refusal and Possible Helpful Suggestions

The following is a list of some common reasons an individual might refuse to take his or her medication and suggestions on how to provide assistance.

Unpleasant Taste

- Give the individual ice chips to suck on just before taking the medication. This will often help mask the bad taste.
- Ask the doctor or pharmacist if the medication can be diluted to cover a bad taste. Ask the physician or pharmacist if there is a juice compatible with the medication that can be used (for example, apple juice). A note to this effect should be on the prescription label.
- Ask the doctor or pharmacist if crackers or juices may be provided afterwards to help cover up the bad taste.

Unpleasant Side Effect - Drowsiness

Report the unpleasant side effect and ask the prescribing doctor if the individual can take the medication at a different time (such as before bedtime). Also, ask about changing the medication or treating the side effect.

Lack of Understanding

Provide simple reminders on what the name of the medication is and what the medication does. For example, "This is Depekene medication that stops your seizures."

Denial of Need for Medication

Discuss the need for the medication, but do not argue. It may help to show the individual a statement written by the doctor; for example, "Alma, you take your heart medication everyday."

Documenting and Reporting

Medication refusal must be documented on the medication record. Contact the prescribing doctor immediately. Refusal of medication may indicate changes in the individual that require the doctor to reevaluate the individual's needs. The doctor may be able to accommodate an individual's medication preference or special health consideration. Any unused dose should be set aside and destroyed in an acceptable way.

> Even though it is not required, it is a good idea to send a Special Incident Report (SIR) to the regional center when an individual that you support refuses their medication.

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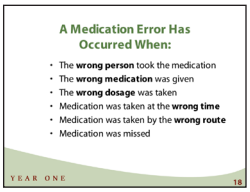
Show Slide #17: Packaging of Medications for Dose Away from Home

- The DSP may package a single dose for each medication needed for no more than a day to be taken at work, day program, or elsewhere.
- With the doctor's written approval, the individual who will take it can carry the medication.
- Without written approval, the medication can be given to a responsible party in an envelope (or container) labeled with the:
  - facility's name, address and phone number.
  - individual's name, name of the medication and instructions for assisting with self-administration of the dose.
- This information relates to an outcome and may appear on the quiz.

  Outcome: Describe procedures for packaging medication for self-administration away from the home.
- Ask the students if a single dose of medication can be packaged to take away from home? If so, how? *Yes, it is permissible for a single dose, so long as the envelope or other container carries the following information: The facility's name, address, and phone number; the individual's name; the name of the medication(s); and instructions for assisting with self-administration.*

Medication Errors

- Preventing medication errors is a priority.



Show Slide #18: A Medication Error has Occurred When and give at least one example of each type of error.

Examples

— The wrong person took the medication: *John took Sara's cough syrup.*

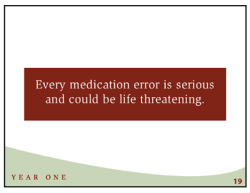
— The wrong medication was given: *John took liquid pain reliever instead of cough syrup.*

— The wrong dosage was taken: *Jean took two tablets instead of one.*

— Medication was taken at the wrong time: *Fred took his evening capsule in the morning.*

— Medication was taken by the wrong route: *Matt used his eye drops for his runny nose.*

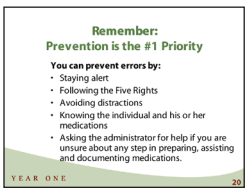
— Medication was missed: *Sally went to work and did not take her morning seizure medication.*



Show Slide #19: Every medication error is serious… and read aloud.

- If an error occurred, report it immediately to the prescribing doctor.
- The error must be recorded in the Medication Log or other document specific to your home with the date, time, doctor's name, instructions given, and actions taken.
- Medication errors are considered special incidents. The error must be reported to Community Care Licensing and the regional center.
- This information relates to an outcome and may appear on the quiz.

  Outcome: Document medication-related information including self-administration, missed doses, errors, side effects, and drug interactions.



Show Slide #20: Remember: Prevention is the #1 Priority and review ways to prevent medication errors.

Packaging of Medications for Dose Away from Home

The DSP may package a single dose of each medication needed for no more than a day to be taken at work, a day program, or elsewhere, such as on a home visit. With the doctor's written approval, the medication can be carried by the individual who will take it. Otherwise, the medication is to be given to a responsible party in an envelope (or similar container) labeled with:

- The facility's name, address, and phone number.
- The individual's name.
- Name of the medication(s).
- Instructions for assisting with self-administration of the dose.

If an individual is regularly taking a dose of medication at school or at a day program, tell the doctor and pharmacist. The doctor may order a separate prescription for a particular dose of medication.

Medication Errors

Every **medication error** is serious and could be life threatening. The DSP's job is to safely assist individuals to receive the benefits of medications. Preventing medication errors is a priority. In this training you have learned the best way to help individuals take medication safely and to reduce the risk of errors. But even in the best of situations, errors may occur. When they do, you need to know what to do.

A medication error has occurred when:

- The **wrong person** took the medication.
- The **wrong medication** was given.
- The **wrong dosage** was taken.
- Medication was taken at the **wrong time**.
- Medication was taken by the **wrong route**.
- Medication was **not** taken.

Every medication error is serious and could be life threatening.

If an error does occur, it must be reported immediately to the prescribing doctor. Follow the doctor's instructions. The error must be recorded either in the Medication Log or other document specific to your home. The record should include the date, time, medication involved, description of what happenned, who was notified, doctor's name, instructions given, and action taken.

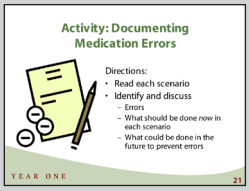
Any medication error is a Special Incident that must be reported to Community Care Licensing and the regional center. Follow the procedures for Special Incident reporting outlined in Session 3 and for the home where you work.

Remember, Prevention Is the #1 Priority.

You can prevent errors by:

- Staying alert.
- Following the **Five Rights.**
- Avoiding distractions.
- Knowing the individual and his or her medications.
- Asking the administrator for help if you are unsure about any step in preparing, assisting, or documenting medications.

Show Slide #21: Activity: Documenting Medication Errors



- Introduce the activity by saying that each facility should have a written policy on medication errors. Encourage students to familiarize themselves with the policy at their facility. Ask the students how many of them know their facility's medication error policy.
- Refer the students to Appendix 5-G and explain:
  - — The general practice for documenting errors is to initial the square or box and put a circle around it. Then on the back of the record, document what occurred.
  - — Call the doctor when a medication error occurs.
  - — Medication errors are considered special incidents and must be reported to Community Care Licensing and the regional center using the reporting procedures you learned in Session 3.
- Groupings: individual, pairs, small group, large group.
- Read the directions aloud.
- Provide students time to read each scenario and answer the questions.
- Facilitate discussion about each scenario.

Answers

Scenario #1

— What was the error? *The medication was administered at the wrong time.*

— What should you do?

- *Notify the doctor that extra doses of Prilosec and Prozac were given.*
- *Follow the doctor's orders.*
- *Observe Ruth Ann for any reactions.*
- *Document the error on the Medication Log (Appendix 5-G) by circling the date and time of the error or omission in the appropriate column on the front of the Medication Log, including the contact and doctor's orders.*
- *Review the back of the Medication Log, for information needed to document errors and omissions.*
- *Complete a Special Incident Report.*

— What can the DSP do to prevent this from happening again? *Carefully check the five rights three times when assisting with the self-administration of medication.*

ACTIVITY

Documenting Medication Errors

Read each scenario and identify the error. Describe what action the DSP should take and what actions can prevent this in the future.

Scenario #1

You are working as a DSP on the evening shift. All six individuals living in the home are present. This morning, Ruth Ann Jones, age 55, moved into the home. Ruth Ann is diagnosed with intellectual disabilities. You are assisting with the evening medications, and this is the first time you are assisting Ruth Ann. When you look at the Medication Log, you notice that Ruth Ann takes many medications. These include:

Prilosec 20 mg daily (8 a.m.)
Prozac 20 mg twice daily (8 a.m. and 12 p.m.)
Haldol 2 mg 3 times a day (8 a.m., 12 p.m., and 5 p.m.)
Inderal 40 mg 3 times a day (8 a.m., 12 p.m., and 5 p.m.)
Peri-Colace 2 capsules at bedtime

You prepare the medications and assist Ruth Ann in taking them. When you sit down to document the medications given, you notice that only two, Haldol and Inderal, were to be given at 5 p.m. You gave the four medications ordered for earlier in the day, which included Prilosec and Prozac, as well as Tegretol and Inderal.

What was the error?

What should you do?

What can the DSP do to prevent this from happening again?

Continued

Activity: Documenting Medication Errors (continued)

Answers (continued)

Scenario #2

— What was the error? *The wrong dose was administered.*

— What should you do?

- *Notify the doctor.*
- *Follow the doctor's orders.*
- *Observe for symptoms of drug reaction.*
- *Document the error on the Medication log, including the contact and the doctor's orders.*
- *Complete a Special Incident Report.*

— What can the DSP do to prevent this from happening again? *Carefully check the five rights three times when assisting with the self-administration of medication.*

Scenario #3

— What was the error? *Medication was unsupervised and the wrong individual took it.*

— What should you do?

- *Notify Mike's doctor immediately.*
- *Check the record to see if Mike has any allergies to the medication he took.*
- *Follow the doctor's orders.*
- *Observe for symptoms of drug reaction.*
- *Give Guy another dose of his medication.*
- *Note in Guy's Medication Log that a dose is missing and explain why. Do not use Mike's name.*
- *Document what and when Mike took the medication in Mike's Medication Log, including the contact and the doctor's orders.*
- *Complete a Special Incident Report.*

— What can the DSP do to prevent this from happening again? *Do not leave medication unsupervised.*

ACTIVITY

Continued from previous page

Scenario #2

You are a DSP working in a small family home for children under the age of 18. There are six children in your home under the age of 8. You have prepared the medications for Sarah, who is 2 years old. The medications include:

- Proventil syrup 2 mg/5ml
  Take 5ml daily in the morning
- Tegretol 100mg/5ml
  Take 5 ml twice daily
- Cisapride 1mg/1ml
  Take 3 ml four times a day, before meals and before sleep

It is 8 a.m. You help Sarah take 5 ml of each medication. When you document on the Medication Log, you notice the Cisapride was ordered 3 ml four times a day.

What was the error?

What should you do?

What can the DSP do to prevent this from happening again?

Scenario #3

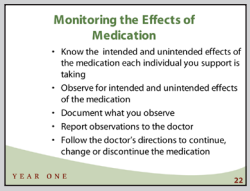
You have prepared morning medications for Guy. Jack calls from another room and wants assistance. You get up and go to the other room. When you return, you see Mike, Guy's roommate, finishing Guy's medication.

What was the error?

What should you do?

What can the DSP do to prevent this from happening again?

Show Slide #22: Monitoring the Effects of Medication and review.



- This information relates to an outcome and may appear on the quiz.

  Outcome: Document medication-related information including: self-administration, missed doses, errors, side effects, and drug interactions.

- DSPs have the responsibility to consistently and accurately observe, report and record any change in the normal daily routine, behavior, ways of communicating, appearance, physical health, and general manner or mood of the individuals they support.
- DSPs are also responsible for giving appropriate care to individuals if serious side effects occur. We will discuss how to respond to medical emergencies in greater detail in Session 8: Signs and Symptoms of Injury and Illness.

Show Slide #23: Monitor closely for side effects… and read aloud.

Monitoring the Effects of Medication

Unintended extra actions of medication, called **side effects**, can occur at any time. Some mild side effects may disappear after a short time. Others may continue the entire time the medication is taken and sometimes beyond. Some side effects are mild while others are life-threatening.

In the home where you work, it is important to learn about the medications each individual is taking. It's also important to know what possible side effects may occur.

The pharmacist is a good source for information about the effects of medication. Medication information sheets should come with every new medication. Pharmacists should talk with each individual receiving a new medication (or change in dose), but you may have to ask questions and request written material. Also, be sure to ask the individual's doctor what kind of reactions should be brought immediately to his or her attention. It is helpful to write possible side effects in the individual's Medication Log and attach the medication information sheet to the individual's record.

Physical and behavioral changes that are due to the effect of a medication are often difficult to identify. There may be many different reasons for the same sign or symptom. A change in behavior may be due to a medication change or a change in the person's environment. A sore throat may be one of the first symptoms of a cold or may be a side effect of a medication.

Your responsibility is to consistently and accurately observe, report, and record any change in the normal daily routine, behavior, ways of communicating, appearance, physical health, and general manner or mood of the individual you support. Interpretation (deciding the meaning) of an observed side effect is the responsibility of the individual's doctor.

Monitoring for the Effects of Medication

- For each individual you support, know the intended and unintended effects of each medication he or she takes.
- Observe for intended and unintended effects of the medication.
- Document what you observe.
- Report observations to the doctor.
- Follow the doctor's directions to continue, change, or discontinue the medication.
- Monitor the individual closely for side effects when a new medication has been prescribed or the dosage increased.

- This information relates to an outcome and may appear on the quiz.

  Outcome: Identify medication side effects and drug interactions.

- Review the list of Common Side Effects of Medication that You Should Report to a Doctor.

Tardive Dyskinesia

- Tardive Dyskinesia (TD) is a potential long-term neurological side effect of antipsychotic medications. Symptoms may include rapid eye blinking, puckering or chewing motions of the lips and mouth, or facial grimacing.
- Discuss this risk with the doctor before an individual starts antipsychotic medications and monitor individuals for these serious side effects on a regular basis.

Show Slide #24: Drug interactions may be caused by interactions between… and review.

- Ask the class if they can name any common drug interactions. Are some interactions found on warning labels? *Yes. For example, "Do not take with milk" or "Do not mix with alcohol."*

Monitoring the Effects of Medication

Common Side Effects of Medication that You Should Report to the Doctor Include:

- Skin rash
- Increased heart rate or feeling like the heart is racing
- Changes in sleep
- Decreased energy
- Excessive sleepiness
- Changes in weight or eating patterns
- Tremors, shakiness
- Balance problems
- Shuffling when walking
- Confusion
- Changes in ability to concentrate
- Hyperactivity
- Abnormal movements (face, tongue, or body)
- Muscle pain
- Stooped posture
- Blank facial expression
- Feeling dizzy or light-headed
- Dry mouth
- Constipation
- Blurred vision
- Diarrhea
- Nausea
- Vomiting
- Increased risk of sunburn

Tardive Dyskinesia

Tardive dyskinesia (TD) is a potential long-term side effect of anti-psychotic medications such as Mellaril, Thorazine, Risperdal, and Zyprexa. Symptoms include involuntary, repetitive, persistent movements, such as rapid eye blinking, puckering, chewing motions, or facial grimacing. Symptoms may worsen if the medication is not reduced or discontinued. TD can become permanent. Discuss this risk with the psychiatrist or doctor before starting antipsychotic medications. Monitor individuals for these serious side effects on a regular basis. If any possible side effects are observed, contact the health care provider immediately.

Medication Interactions

Medication interactions may occur between two or more drugs and between drugs and food and drink. Medication interactions may cause unwanted side effects.

Drug interactions may be between:

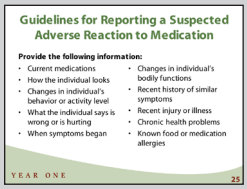
- Two or more drugs
- Drugs and food
- Drugs and drink

Alcohol, a common drug, in combination with any of the following medications is especially dangerous**:**

- Antianxiety drugs, such as Librium, Valium, or Xanax.
- Antidepressants.
- Antiseizure medicines.
- Antihistamines.
- Ulcer and heartburn drugs such as Zantac® and Tagamet®.
- Some heart and blood pressure medicines.

Trainer Guide: SESSION 5

Show Slide #25: Guidelines for Reporting a Suspected Adverse Reaction to Medication



- Review the information that should be given to the doctor when a reaction to medication is suspected.
- This information relates to an outcome and may appear on the quiz.

  Outcome: Describe required reporting procedures in cases of medication side effects and drug interactions.

Show Slide #26: Severe, Life-Threatening Allergies

- Tell students to call 911 immediately of signs of a severe allergic reaction develop.
- This information relates to an outcome and may appear on the quiz.

  Outcome: Identify appropriate responses to severe side effects that may be life threatening.

Following Doctor's Orders for Tests

- Review information in the Student Guide.
- Some medications (Tylenol, Lithium, Depakene) can be toxic and cause damage.
- Some individuals respond differently to medications; some use and break down medications in their body slower or faster than others.
- For these two reasons, doctors will test blood serum levels.
- Doctor's orders for lab tests and follow-up appointments must be followed.

Guidelines for Reporting a Suspected Adverse Reaction to Medication

When you suspect that the individual is having a bad reaction to a medication, urgent medical care may be needed. Report the suspected reaction to the doctor and follow the doctor's advice. When you talk to the doctor, be prepared to give the following information:

- A list of the individual's current medications.
- Description of how the individual looks (pale, flushed, tearful, strange facial expression, covered in red spots).
- Description of any changes in individual's behavior or level of activity.
- Description of what the individual says is wrong or is hurting.
- When the symptoms of a reaction first started.
- Description of any changes in bodily function:

  Is the individual eating or drinking? Does he or she have a good appetite or no appetite? Any nausea, vomiting, diarrhea, constipation, problems urinating?
- Description of any recent history of similar symptoms, any recent injury or illness, or any chronic health problem.
- Description of any known allergies to food or medication.

Severe, Life-Threatening Allergies (Anaphylaxis)

Some individuals have a severe sensitivity, or **allergic reaction**, to medications, especially penicillin. The allergic reaction is sudden and severe and may cause difficulty breathing and a drop in blood pressure (anaphylactic shock). If an individual has had a severe allergic reaction to a medication (or insect stings or food), he or she should wear an identification bracelet that will tell health professionals about the allergy.

Call 911 immediately to get emergency medical care if signs of a severe allergic reaction develop, especially soon after taking a medication. Signs of an allergic reaction include:

- Wheezing or difficulty breathing.
- Swelling around the lips, tongue, or face.
- Skin rash, itching, feeling of warmth, or hives.

Some individuals have a severe allergy to insect stings or certain foods. If an individuals shows any of these same signs of a severe allergic reaction soon after eating a food or being stung by an insect, call 911 immediately to get emergency medical care.

Following Doctor's Orders for Tests

Some medications (Tylenol®, Lithium, Depakene) can be toxic and cause damage, especially if taken for a long period of time. Some individuals respond differently to medications; that is, some use and break down medications in their body slower (or faster) than others. For this reason, physicians sometimes start a new medication at low doses and increase it in response to signs of a desired effect, such as fewer seizures or better sleep patterns.

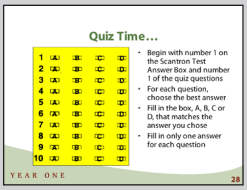
Blood tests that analyze the levels of medications in an individual's blood can be important. Physician's orders for lab tests and follow-up appointments must be followed. Blood tests help the physician determine the effectiveness of the medication and the future course of treatment.

- Ask students to turn back to the "What Do You Want to Know?" activity at the beginning of the session. Give students 5 minutes to think about what they learned and asnwer the third question.
- Ask for volunteers to share their answers.

Show Slide #27: Practice and Share

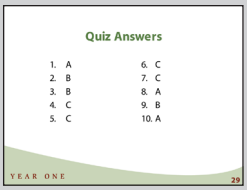
- Direct students to Practice and Share directions.
- Read the directions and make sure students understand the assignment.

Show Slide #28: Quiz Time...



- Review the directions for filling out the Scantron form.
- Give students 20 minutes to take the quiz.

Show Slide #29: Quiz Answers



- Discuss quiz and answers as a class.
- Remind students to mark the correct answers so they can use the corrected quizzes as a study guide for the test after training.

Answers

1. *A*
2. *B*
3. *B*
4. *C*
5. *C*
6. *C*
7. *C*
8. *A*
9. *B*
10. *A*

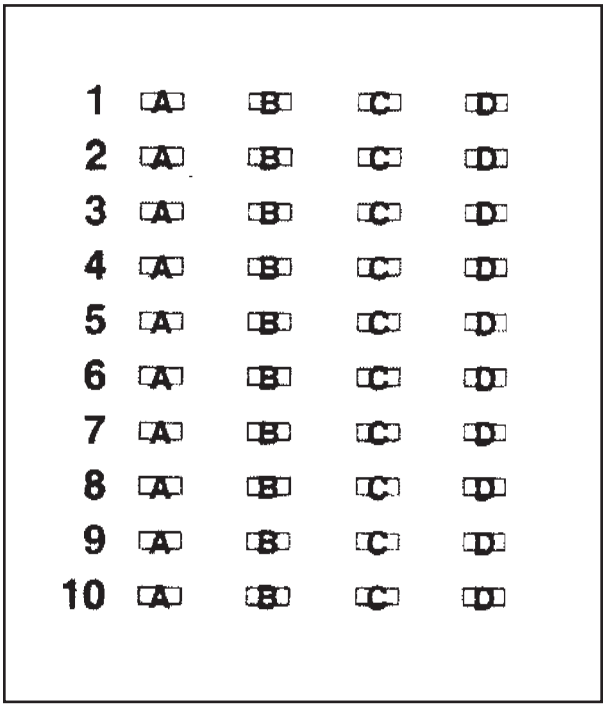
End of Session 5.

PRACTICE AND SHARE

Talk to your administrator and review your facility's procedures for documenting medication errors. Be prepared to share what you find out at the next class meeting.

Session 5 Quiz

Medication Management, Part 2



1. **Which is the "best practice" standard of medication management for the DSP?**
   A) record every medication dose and every medication error.
   B) record only the first and last medication doses of each day.
   C) record medication errors that occur twice or more in a 24-hour period.
   D) record any medication doses.

2. **Which choice below is the best source of information on the side effects of medication?**
   A) an individual's parents or family.
   B) a medication information sheet from the pharmacy or a doctor.
   C) television advertisements about the medications.
   D) the facility administrator and other DSPs.

3. **A PRN medication:**
   A) is administered whenever the DSP decides.
   B) must be ordered by a doctor.
   C) is only over-the-counter medication.
   D) does not have to be recorded in the individual's Medication Log.

4. **When a medication error occurs:**
   A) the error requires special incident reporting only if it is life-threatening.
   B) both 911 and the individual's doctor must be informed.
   C) the error must be reported to the regional center as a Special Incident.
   D) the facility administrator decides whether a Special Incident Report is needed.

5. **The Medication Log must be updated:**
   A) as soon as a new DSP comes on duty.
   B) as indicated by directions on the medication label.
   C) whenever a prescription is changed.
   D) at least one hour before each medication.

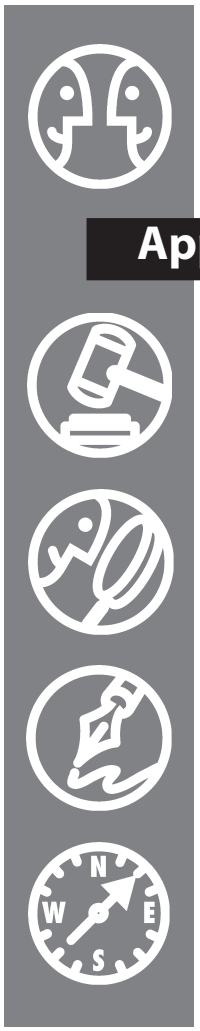
6. **Community Care Licensing regulations require that all drugs in the home must be:**
   A) bought at a local pharmacy.
   B) located near the individual for whom they are prescribed.
   C) logged in a medication record.
   D) carried by the DSP responsible for their administration.

7. **When an individual's medication is discontinued:**
   A) it should be stored in a locked cabinet.
   B) it may be given to another individual.
   C) it may be destroyed by the facility administrator.
   D) it may not be returned to the pharmacy.

8. **If a medication error results in a life threatening situation, the DSP should:**
   A) call 911 for assistance immediately.
   B) speak to the individual's doctor before taking any action.
   C) wait until the individual has difficulty breathing before calling 911.
   D) speak with the facility administrator before taking any action.

9. **Medication taken away from the care facility must be packaged:**
   A) in a box with the pharmacy's name and phone number.
   B) with a label for the facility's name, address and phone number and the individual's name, name of medication and instructions.
   C) with instructions for administration.
   D) with the name and phone number of the DSP and a copy of the medication information sheet.

10. **Drug interactions can occur between:**
    A) two or more drugs.
    B) two different people.
    C) drugs and water.
    D) alcohol and food.



Appendices

Appendix 5-A

Centrally Stored Medication and Destruction Log

STATE OF CALLIFORNIA HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

CENTRALLY STORED MEDICATION AND DESTRUCTION RECORD

I. CENTRALLY STORED MEDICATION

INSTRUCTIONS: *Centrally stored medications shall be kept in a safe and locked place that is not accessible to any person(s) except authorized individuals. Medication records on each client/resident shall be maintained for at least one year.*

FACILITY NAME: Molina Family Home
FACILITY NUMBER:

NAME (LAST)	FIRST	MIDDLE)	ADMISSION DATE	ATTENDING PHYSICIAN	ADMINISTRATOR
Anthony	Susan				

MEDICATION NAME	STRENGTH/ QUANTITY	INSTRUCTIONS CONTROL/CUSTODY	EXPIRATION DATE	DATE FILLED	DATE STARTED	PRESCRIBING PHYSICIAN	PRESCRIPTION NUMBER	NO. OF REFILLS	NAME OF PHARMACY
Lamictal	25 mg tab /200 tabs		01/02	MM/5	MM/12	Dr. Rodriquez	012346	2	Not given

II. MEDICATION DESTRUCTION RECORD

INSTRUCTIONS: *Prescription drugs not taken with the client/resident upon termination of services or otherwise disposed of shall be destroyed in the facility by the Administrator or Designated Representative and witnessed by one other adult who is not a client/resident. All facilities except Residential Care Facilities for the Elderly (RCFEs) shall retain destruction records for at least one year. RCFEs shall retain records for at least three years.*

MEDICATION NAME	STRENGTH/ QUANTITY	DATE FILLED	PRESCRIPTION NUMBER	DISPOSAL DATE	NAME OF PHARMACY	SIGNATURE OF ADMINISTRATOR OR DESIGNATED REPRESENTATIVE	SIGNATURE OF WITNESS ADULT NON-CLIENT
Lamictal	25 mg tab /124 tabs	01/02	012346	MM/28	Not given	Juan Molina	Suzy Smith

Appendix 5-B

Common Medication Categories

Drugs are classified into categories with other medications that affect the body in similar ways. Thousands of medications are on the market in many categories. Here is a list of medication categories and examples as categorized by the U.S. Food and Drug Administration*:

- Anesthetic: Topical, ophthalmic, etc.
- Antidotes: Antitoxins, anaphylaxis treatment
- Antimicrobial: Antibiotics, antifungals
- Hematologic: Anticoagulants, blood substitutes
- Cardiovascular-renal: Antihypertensives, diuretics
- Central nervous system: Sedatives, antianxiety, antipsychotic and antidepressant medications
- Gastrointestinal: Antidiarrheals, laxatives, antacids
- Hormones: Estrogen, thyroid medication, contraceptives
- Immunologics: Vaccines
- Metabolic/nutrients: Vitamins, supplements
- Mucous membrane/skin: Disenfectant, antiperspirant, Sunscreen, acne products
- Neurologic: Anticonvulsants
- Oncolytics: Antibiotics, antimetabolites
- Ophthalmics: Decongestants, antiallergy medication, contact lens products
- Otologics: ear drops, motion sickness medication
- Relief of pain: Analgesics, antimigraine and antiarthritic medications
- Antiparasitics: Scabicides
- Respiratory tract: Antiasthmatics, bronchodilators, cold sore and canker medication
- Homeopathic products

Many drugs, because of their multiple uses, can be found in more than one category. For example, Benadryl® is an antihistamine, which relieves allergy symptoms. It's also a sedative to promote sleep.

* The FDA plans to review the current classification scheme because it has not been updated recently and many new molecular entities are not included. Information accessed February 2010 at http://www.fda.gov/Drugs/InformationOnDrugs/ucm142438.htm

Appendix 5-C

Community Care Licensing
Incidental Medical Services

Requirements for Health Related Services

By law, CCFs provide non-medical, residential services. Over the years, however, legislative and regulatory changes have permitted certain health-related services to be delivered in CCFs. These changes include:

- Hospice care homes for the elderly.
- Certain specialized health care services for medically fragile children.
- Incidental medical care for adults.

It is unlawful for CCFs to accept (or retain) individuals who have certain health care needs that require nursing services.

Individuals with restricted health conditions—for example, who have the need for oxygen or insulin-dependent diabetes—can be served in CCFs if the following standards are met:

- Willingness of the licensee to provide needed care.
- The condition is stable or, if not, temporary and expected to become stable.
- The individual is under the care of a licensed professional.
- A licensed health professional provides training and supervision to unlicensed staff assisting with special or incidental medical care.

Services and support to children and adults with special or incidental medical care needs are beyond what is covered in this module and will not be discussed further. Staff working in homes that provide special or incidental medical care must be trained and supervised by a licensed health care professional and follow an individual Health Care Plan.

Incidental Medical Services

Prohibited Health Conditions:

Individuals who require health services or have the following health conditions cannot be served in community care licensed Adult Residential Facilities (ARFs):

- Naso-gastric and naso-duodenal tubes
- Active, communicable tuberculosis (TB)
- Conditions that require 24-hour nursing care and or monitoring
- Stage 3 and 4 dermal ulcers
- Any other condition or care requirements which would require the facility to be licensed as a health facility

Restricted Health Conditions:

Individuals with the following conditions may be served in an ARF if the requirements for restricted health conditions are met:

- Use of inhalation-assistive devices
- Colostomy or ileostomy
- Requirement for fecal impaction removal, enemas, suppositories
- Use of catheters
- Staph or other serious, communicable infections
- Insulen-dependent diabetes
- Stage 1 or 2 dermal ulcers
- Wounds
- Gastrostomies
- Tracheostomies

Appendix 5-D

Eye Drops and Eye Ointment

Ophthalmic medications are those put into an individual's eyes. They may be in eye drop or ointment form.

1. Wash hands.
2. Explain procedure to individual and position him or her, either sitting with head tilted back or lying down.
3. Have a clean separate tissue, gauze, or cotton ball available for each eye.
4. Wipe the lid and eyelashes clean before instillation of the eye drop. Always wipe from inside to outside. Always use fresh gauze or tissue to clean each eyelid.
5. If an eyedropper is used, draw up only the amount of solution needed for administration.
6. Hold the applicator close to the eye, but do not touch eyelids or lashes. This will keep the applicator clean and free from bacteria.
7. Instruct the individual to look up. Place index finger on cheekbone and gently pull lower lid of the eye down to form a pocket.
8. For eye drops, instill (drip) the prescribed number of medication drops into the pocket formed by the lower lid. For eye ointment, put a thin line of ointment in the pocket. Avoid dropping medication on the cornea, as this may cause tissue damage and discomfort.
9. Release lower lid and let individual blink to distribute medication.
10. Wipe excess liquid with gauze or clean tissue and make comfortable. Observe. Eye ointment can cause some temporary blurring of vision.
11. Instruct the individual to keep eye closed for one to two minutes after application to allow for absorption of the medication. Caution the individual not to rub his or her eyes.
12. Recap medication and store bottle away from heat and light in locked medication storage area.

Ear Drops

Otic medications are those put into an individual's ears. Typically, otic medications are in liquid drop form.

1. Wash hands.
2. Explain to the individual what you are going to do as you warm the drops to body temperature by holding the bottle in your hand for a few minutes before applying.
3. Have the individual lie on his or her side with the ear to be treated facing upward.
4. For adults, gently pull the ear lobe away from their neck. Hold the dropper over the ear opening and allow the prescribed number of drops to fall into the ear.

   Caution: Never use an ear wick or gauze to administer drops into the ear. The individual's doctor will provide special instructions if ear wicks and ear packs are to be used.
5. For children under 3 years of age, pull the external part of the ear down and back. Hold the dropper over the ear opening and allow the drops to fall into the ear. Take care not to contaminate the dropper by touching the external ear.
6. Have the individual remain on his or her side for a few minutes after administering to allow medication to spread into the ear canal and be absorbed.
7. If both ears require medication, leave individual on his or her side for a few minutes and then repeat procedure in the other ear.
8. Give individual a tissue to wipe away excess liquid. Observe.
9. Recap medication and store bottle away from heat and light in locked medication storage area.

Appendix 5-F

Topical Medications

Topical medications are those applied directly to the skin or to certain areas of the body. Topical medications are usually lotions or creams.

1. Wash your hands and put gloves on carefully. Very frequently, if an individual has a problem requiring topical application of a liquid, cream, or an ointment, the skin will not be intact but will have breaks or sores on the surface.
2. Explain to the individual what you are going to do.
3. Being mindful of privacy, assist the individual to expose the area where the topical medication is to be applied. Make sure clothing and bedding are protected.
4. Open the container and remove the prescribed amount of the product to be applied.
5. Gently apply the lotion or cream, following the instructions on the medication label.
6. Remove gloves carefully and dispose of using standard precautions.
7. Wash your hands.
8. Recap container and return to locked storage area.

Medication Log

Facility Name ______________________ Address ______________________ Phone Number

Name: ______________________ Insurance: ❏ Medi-Cal ❏ Medicare ❏ Insurance No.______________

Drug/Strength/Form/Dose	Hour	Month & Year (MM/YY) ______________ & Date______________																														
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Primary Care Physician: ______________________ Pharmacy: ______________________

Staff Signatures & Initials: ________for ______________ ________for ______________ ________for ______________

notes: • *Staff initials date and time medication is taken*
• *If medication is taken at another location, use:*
D= Day Program R= Relative or friend's home E= Elsewhere

Allergies:

Appendix 5-G

Errors and Omissions

Date	Time	Medication Involved	Description of what happened (How discovered, effect upon person, sequence of events and individuals)	Who was notified, e.g. Doctor, Administrator, Emergency Services, etc.	Initials

Primary Care Physician: _____ Pharmacy: _____

Staff Signatures & Initials:_____for _____ _____for _____ _____for _____

notes: • *Staff initials date and time medication is taken*
• *If medication is taken at another location, use:*
D= Day Program R= Relative or friend's home E= Elsewhere

Allergies: